Convention on the Elimination of All Forms of Discrimination against Women

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Committee on the Elimination of Discrimination against Women

Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women

Report of the Committee

I. Introduction

1. On 9 December 2010, the Committee on the Elimination of Discrimination against Women received information from several organizations[1] pursuant to article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women. The sources allege that the United Kingdom of Great Britain and Northern Ireland has committed grave and systematic violations of rights under the Convention owing to the restrictive access to abortion for women and girls in Northern Ireland.

2. The United Kingdom ratified the Convention on 7 April 1986 and acceded to the Optional Protocol on 17 December 2004.

II. Submission by the sources of information

3. The sources submit that, in Northern Ireland, assisting with or procuring an abortion is criminalized, punishable by a maximum sentence of life imprisonment,[2] and the availability of abortion is highly restricted. They allege a failure on the part of the United Kingdom, inter alia: (a) to establish a comprehensive legal framework to protect and guarantee women in Northern Ireland the right to abortion; (b) to ensure that women in Northern Ireland are not exposed to the health risks of unsafe abortion; and (c) to address social, practical and financial obstacles to access to abortion, obstacles that disproportionately affect rural women. The sources allege that the legal framework on abortion discriminates against women in Northern Ireland. In addition,

[1] The Family Planning Association, Northern Ireland Women's European Platform and Alliance for Choice.

[2] Sections 58 and 59, Offences against the Person Act, 1861; section 25 (1), Criminal Justice Act (Northern Ireland) 1945.

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access to abortion is impeded by the prevailing anti-choice rhetoric in churches, schools and local politics.

III. Procedural history

4. On 20 January 2014, the United Kingdom submitted its observations on the request for an inquiry, indicating that it was lawful to perform an abortion in Northern Ireland when necessary to preserve the woman's life or when there existed a risk of real and serious long-term or permanent adverse effects to the woman's physical or mental health. It noted that, although procuring an abortion was criminalized, prosecutions were rare, and residents of Northern Ireland could travel to other countries forming part of the United Kingdom, although they were not entitled to coverage by the National Health Service and must pay privately, or internationally to gain access to abortion services where they were available. The United Kingdom denied any breach of its obligations and asserted that a revision of its legislation was not envisaged.

5. In November 2014, the United Kingdom submitted information in follow-up to the concluding observations of the Committee on its seventh periodic report (CEDAW/C/GBR/CO/7/Add.1). At its sixtieth session, from 16 February to 6 March 2015, the Committee considered that the United Kingdom had not implemented its recommendation to decriminalize abortion and had only partially implemented its recommendation to expand the grounds for legal abortion, following the recommendation contained in the consultation paper published on 8 October 2014 that amendments be made to legislation to allow abortion in cases of "lethal abnormality of the foetus".

6. From its fifty-seventh to sixty-first sessions, the Committee examined all information received and found the allegations to be reliable and indicative of grave or systematic violations of rights under the Convention. It designated Ruth Halperin-Kaddari and Niklas Bruun to conduct an inquiry.

7. The United Kingdom, on 29 January 2016, agreed to the visit of the designated members to Belfast and London. The visit was conducted from 10 to 19 September 2016, during which the designated members and two members of the secretariat of the Committee met with the Minister for Communities, the Minister of Justice and the Attorney General and officials from the Department of Health, the Northern Ireland Human Rights Commission, the Equality Commission for Northern Ireland and the office of the Northern Ireland Commissioner for Children and Young People. They visited a public hospital and a private clinic in Belfast where abortions are performed and interviewed health-care professionals and management. They interviewed members of the Northern Ireland Assembly from five political parties, representatives of civil society groups, academia and trade unions and numerous women who had sought or had procured an abortion. In London, they met with representatives of the Foreign and Commonwealth Office, the Department for Education, the Department of Health and the Northern Ireland Office. They also met with representatives of the Abortion Support Network and the British Pregnancy Advisory Service. The designated members obtained information from organizations supplying abortifacients to women in Northern Ireland.

IV. Legal framework on termination of pregnancy in Northern Ireland

8. Sections 58 and 59 of the Offences against the Person Act, 1861, and section 25 (1) of the Criminal Justice Act (Northern Ireland), 1945, regulate abortion in Northern Ireland. The latter provision mirrors sections 1 and 2 of the Infant Life (Preservation) Act, 1929, of Great Britain, under which it is an offence to intentionally kill a child capable of being born alive before it has a life independent of its mother. It is a defence under the Infant Life (Preservation) Act to show that the death was caused in good faith to preserve the life of the pregnant woman. The Offences against the Person Act, as modified by *R v. Bourne*[3] and subsequent jurisprudence in Northern Ireland, extends the grounds for lawful abortion to include situations where it is necessary to preserve the life of the pregnant woman or in which there is a risk of real and serious adverse effects to the woman's physical or mental health, whether long term or permanent. Whereas the Court of Appeal of Northern Ireland recently noted that the current law on abortion prioritized protecting, to a reasonable extent, the life that women could enjoy independent of the state of health of the fetus,[4] procuring, aiding and abetting abortions in cases of rape, incest and severe fetal impairment, including fatal fetal abnormality, remained criminalized, carrying a maximum penalty of life imprisonment.

9. The Abortion Act, 1967, as amended by section 37 of the Human Fertilisation and Embryology Act, 1990, permits abortions only in England, Scotland and Wales, inter alia, in cases in which: (a) the pregnancy has not exceeded its twenty-fourth week and its continuation would involve a risk greater than if it were terminated; (b) it is necessary to prevent grave permanent injury to the physical or mental health of the woman; or (c) a substantial risk exists that the child, if born, would suffer from such physical or mental abnormalities as to be seriously "handicapped".

10. Since the signature of the Belfast Agreement in 1998, under which certain powers were devolved to Northern Ireland, Scotland and Wales, notable developments with regard to abortion in Northern Ireland have included the following: (a) the rejection by the Northern Ireland Assembly of extending the Abortion Act, 1967, to Northern Ireland (21 June 2000); (b) the launch of a public consultation on draft guidance on abortion for medical practitioners (16 January 2007); (c) the issuance (16 July 2008) and withdrawal (30 November 2009) of revised draft guidance on abortion for consultation, followed by the release of new guidance (27 July 2010); (e) the rejection of an amendment to criminalize the performance of legal abortions at private clinics (12 March 2013); (f) the issuance of draft guidance on abortion (8 April 2013); (g) the launch of a consultation on amendments to legalize abortion in cases of "lethal foetal abnormality" and sexual crimes, and the regulation of conscientious objection (7 October 2014); (h) the rejection of an amendment to restrict the performance of an abortion to National Health Service establishments except in urgent cases (3 June 2015); (i) the decision of the High Court of Justice in Northern Ireland declaring the legal framework of Northern Ireland on abortion to be incompatible with article 8 of the Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights) (30 November 2015);[5] (j) the rejection of two motions to amend the justice bill to legalize abortion in cases of fatal fetal abnormality and sexual crimes (11 February 2016); (k) the issuance of new guidance on abortion (25 March 2016); and (l) the conviction of a 21-year-old woman for self-administering abortifacients (5 April 2016). During the

[3] *R v. Bourne* [1939] 1 KB 687.

[4] *Attorney General v. Northern Ireland Human Rights Commission* [2017] NICA 42, para. 79.

[5] Northern Ireland Human Rights Commission, application for judicial review [2015] NIQB 96.

visit, prosecutions were under way of women reported by hospital staff following treatment of complications resulting from self-administered abortifacients, including a mother who purchased abortifacients online for her teenage daughter, and a foreign woman.

11. On 14 June 2017, the Supreme Court of the United Kingdom rejected an appeal that challenged the failure by England to extend National Health Service coverage to women in Northern Ireland seeking a legal abortion in England, citing the need to "afford respect to the democratic decision of the people of Northern Ireland".[6] On 29 June 2017, however, the Minister for Women and Equalities of the United Kingdom announced that, thenceforth, such coverage would extend to women in Northern Ireland seeking access to abortion in England.[7]

12. On 29 June 2017, the Court of Appeal in Northern Ireland allowed an appeal against an order made by Justice Horner, in which he declared sections 58 and 59 of the Offences against the Person Act and section 25 of the Criminal Justice Act incompatible with article 8 of the European Convention on Human Rights, insofar as it was an offence to procure an abortion in cases of fatal fetal abnormality, rape or incest.[8] While the appeal was allowed, the decision of the Chief Justice instructs the legislature to urgently address "the pressing need to ensure that there is a practical and effective method of implementation of rights of women" regarding access to abortion.[9]

V. Findings of fact

A. Access to abortion

1. De facto limitations on access to legal abortions in Northern Ireland

(a) Institutional and geographical limitations

13. In the period 2015–2016, only 46 abortions were performed in public hospitals in Northern Ireland,[10] yet, in stark contrast, 724 women travelled from Northern Ireland and procured an abortion in England.[11] The designated members learned from the outset that the accessibility of both medical and surgical abortion was limited by institutional and geographical factors. All services were concentrated in two facilities located in Belfast: the Royal Maternity Hospital, the only public facility currently performing abortions in very limited cases of fatal fetal abnormality; and the Marie Stopes International clinic, the only private facility performing medical abortions until 9.4 weeks' gestation exclusively under the mental and/or physical health exception.

[6] *R (on the application of A and B) v. Secretary of State for Health* [2017] UKSC 41, p. 9.

[7] Letter dated 29 June 2017 from Minister for Women and Equalities Justine Greening addressed to members of the House of Commons.

[8] See footnote 4 above.

[9] Ibid., para. 85.

[10] Department of Health, Social Services and Public Safety of Northern Ireland, Northern Ireland Termination of Pregnancy Statistics 2015/16, table 1, indicating that there were 46 abortions (30 medical, 16 surgical) during that period. "Medical abortion" refers to termination of pregnancy induced by abortifacient pharmaceutical drugs used until 9 weeks' gestation. "Surgical abortion" entails removal of the foetus and placenta from the uterus through vacuum aspiration or dilatation and evacuation.

[11] Department of Health of the United Kingdom, "Abortion statistics, England and Wales: 2016" (June 2017), p. 71.

(b) Lack of clarity on when an abortion can be performed legally

14. Health professionals are equally liable to a penalty of life imprisonment for aiding and abetting the procurement of an abortion.[12] A consultation on draft guidance for health professionals on the circumstances in which an abortion can be performed legally was conducted in 2013.[13] Issued by the Department of Health, Social Services and Public Safety, the stated purpose of the draft guidance was "to guide clinicians on the application of the very strict and narrow criteria that are consistent with the law".[14]

15. The Committee is of the view that the finalized guidance of the Department[15] of March 2016 does not clarify the circumstances in which abortions are lawful in Northern Ireland. Health professionals are responsible for assessing, on a case-by-case basis, whether a woman's clinical circumstances meet the legal criteria for an abortion.[16] The guidance recommends that two doctors with appropriate skills and expertise undertake the assessment. In practice, no clinicians are designated and no protocol exists to guide the assessment. The designated members were informed that the risk of the penalty of life imprisonment for interpreting the law incorrectly discourages clinicians from making a referral for abortion.

16. It is indicated in the guidance that "the impact of foetal abnormality on a woman's physical or mental health may be a factor to be taken into account when a health professional makes an assessment of a woman's clinical condition and recommends options for her on going care".[17] However, it does not clarify whether abortion is an option. The Committee notes that the Chief Medical Officer tasked the Public Health Agency and the Health and Social Care Board and Trusts to "work together to ensure that appropriate arrangements for care and support are in place to allow all eligible women access to termination of pregnancy services", and to "liaise to develop regional information leaflets on termination of pregnancy".[18] However, no clear communication strategy exists for health professionals or the public on the circumstances in which access to legal abortions can be obtained. The Committee finds that the ambiguous legal and policy framework of Northern Ireland does not provide a clear pathway for the care of women requiring an abortion.

(c) Chilling effect on clinicians

17. The downward trend[19] of legal abortions performed in Northern Ireland since 2013 is attributable to the increasing unwillingness of clinicians to make referrals for or to perform an abortion, owing to increased fear of criminal liability. The designated members learned that, between 2003 and 2008, abortions were available in cases of fatal fetal abnormality, because clinicians interpreted the law favourably using the mental health exception. The subsequent increased scrutiny of abortions by authorities resulted in fewer abortions being performed in public hospitals. In 2009, the then Minister of Health launched an investigation into every abortion performed in cases of fatal fetal abnormality under the mental health exception. Between 2011

[12] See footnote 2 above.

[13] Department of Health, Social Services and Public Safety, "The limited circumstances for a lawful termination of pregnancy in Northern Ireland: a guidance document for health and social care professionals on law and clinical practice" (April 2013).

[14] Ibid., para. 1.3.

[15] Department of Health, Social Services and Public Safety, "Guidance for health and social care professionals on termination of pregnancy in Northern Ireland" (March 2016).

[16] Ibid., p. 5.

[17] Ibid., para. 2.9.

[18] Letter dated 25 March 2016 from the Chief Medical Officer of Northern Ireland addressed to the Public Health Agency, the Health and Social Care Board and the Health and Social Care Trusts.

[19] See footnote 10 above, table 1.

and 2012, the Minister requested medical practitioners to record personal details about the women and the reasons for the abortions.[20]

18. The Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Nursing in Northern Ireland have described the draft guidance that was consulted upon in 2013 as intimidating to both women and health-care professionals.[21] In their view, it creates uncertainty and fear, resulting in a chilling effect on the performance of abortions. The Committee finds that the finalized guidance of 2016 perpetuates such intimidation given that it states the following: "A health and social care professional has a legal duty to refuse to participate in any procedure leading to termination of pregnancy if it would be an offence under the law of Northern Ireland. Under section 5 of the Criminal Law Act (Northern Ireland) 1967, if they know or believe that such an offence has been committed and have information which is likely to be of material assistance in securing the apprehension, prosecution, or conviction of the person who committed it, then they are under a duty to give that information within a reasonable time to the police. Failure to do so without a reasonable excuse is an offence which upon conviction carries a maximum penalty of ten years imprisonment."[22] The result is the continuing restriction of abortions in Northern Ireland.

(d) Inability to gain access to services owing to harassment by anti-abortion protesters

19. The designated members learned that women's access to legal abortion services in Northern Ireland was further impeded by the presence and actions of anti-abortion protesters stationed at entrances to public and private health facilities. The designated members witnessed protesters monitoring women entering and leaving a facility and displaying large, graphic posters of disfigured fetuses. The designated members heard testimony of protesters having chased women leaving the facilities, forcing plastic baby dolls into their arms and pro-life literature into their bags and pleading with them "not to murder their babies". One facility has recruited escorts to shield clients from such aggressive behaviour. Although the police are frequently alerted to the situation, they rarely intervene.

20. In conclusion, the Committee finds that, the legal provision for abortion in very limited circumstances notwithstanding, de facto limitations render access to abortion virtually impossible. They include: (a) the geographical and institutional limitation of services; (b) ambiguity regarding the circumstances for performing a legal abortion; (c) clinicians' unwillingness to perform abortions owing to intimidating and hostile working environments resulting from threats of prosecution; and (d) the impunity of anti-abortion protesters for assaults perpetrated against women seeking abortion.

2. Reality of illegal abortions in Northern Ireland

21. Since 2000, the police in Northern Ireland have investigated more than 30 cases of individuals suspected of procuring an abortion.[23] Between 2006 and 2015, they

[20] Health Minister of Northern Ireland, Edwin Poots, written statement of 22 August 2012 to the Northern Ireland Assembly.

[21] Feedback to the Department of Health, Social Services and Public Safety on the draft guidance (July 2013).

[22] See footnote 15 above, para. 9.4. See also footnote 4 above, paras. 61–62.

[23] F. Bloomer et al., "Moving forward from judicial review on abortion in situations of fatal foetal abnormality and sexual crime: the experience of health professionals" (July 2016), report to the Reproductive Health Law and Policy Advisory Group, p. 8.

made 11 arrests relating to illegal abortion.[24] Between 2011 and 2016, five people were questioned and arrested for possession of abortifacients; two were convicted.[25]

22. Information reveals a rise in the self-administration of medical abortions, which is criminal, by women unable to travel outside Northern Ireland and whose pregnancies are at less than nine weeks' gestation. That upward trend is attributed to the presence of non-profit organizations providing early medical abortions outside the formal health-care system by means of telemedicine since 2006. Although no official data exist on the extent of the phenomenon in Northern Ireland, an online supplier of abortifacients provided the designated members with information on purchasers, including women in Northern Ireland. Those women represent a wide age range, including women under 20 years of age and over 45, with most between 30 and 35 years of age, identifying as married, cohabiting or unmarried.

23. The guidance finalized in 2016 addresses the use of abortifacients purchased through the Internet as follows: "Their use to secure a miscarriage in Northern Ireland is likely to be an offence under the Offences against the Person Act".[26] The guidance obligates health professionals to provide appropriate treatment to women suspected of having self-administered abortifacients. It continues: "Health and social care professionals working in clinical situations need to be assured that procedures they are involved in are lawful. [They] must balance the need for confidentiality of patients with the obligation to report unlawful terminations of pregnancy to the police and the need to protect others from risk of serious harm."[27] The designated members received testimony that, to avoid having to report women presenting with post-abortion complications to the police, women were neither asked, nor encouraged to reveal, whether they had ingested abortifacients. Health-care professionals stated that the "don't ask, don't tell" practice was untenable, because it presented a barrier to providing appropriate medical care.

24. The Committee acknowledges the significant health risks associated with ingesting counterfeit abortifacients obtained through the Internet from unverifiable sources and notes that the only dedicated assistance for women who have self-administered abortifacients is the telephone helpline of the British Pregnancy Advisory Service, a non-governmental organization in Great Britain. It is of concern, therefore, that the guidance, in effect, discourages women from seeking care for post-administration complications, for fear of criminal sanction.

3. Travelling outside Northern Ireland for abortion

(a) Access to abortion services in England

25. Between 1970 and 2015, 61,314 abortions in England were performed on residents of Northern Ireland.[28] Some 16 per cent of all abortions performed annually on non-residents of England and Wales are provided to women from Northern Ireland.[29] In 2016, 5 abortions were performed on girls under 16 years of age, and 19 on girls between 16 and 17 years of age.[30] The majority of procedures occurred at between three and nine weeks' gestation, with only 3 per cent of abortions performed

[24] Freedom of information request No. F-2015-02701, "Charges relating to arrests relating to abortion".

[25] Freedom of information request No. F-2016-01040, "Abortion pills".

[26] See footnote 15 above, paras. 6.5–6.8.

[27] Ibid., paras. 6.1 and 6.4.

[28] Bloomer, Fiona et al, "Northern Ireland overview of monitoring data on abortions", report to the Reproductive Health Law and Policy Advisory Group (June 2017).

[29] See footnote 6 above, para. 53.

[30] See footnote 11 above, table 12c.

at 20 weeks' gestation or later.[31] The phenomenon is acknowledged by authorities in both Northern Ireland and England through the collection of official statistics. Interviewees attested that the statistics presented an underestimate, owing to the lack of traceability of all women undergoing an abortion extraterritorially; some may not indicate their address in Northern Ireland to the service provider, whereas others may travel internationally. The number of abortions provided to non-residents of England and Wales has fallen each year since 2003.[32] The Committee has drawn a link between those figures and the rising use of abortifacients in Northern Ireland.[33]

26. Until recently, the National Health Service covered abortion costs only for residents of England, Scotland and Wales, excluding women from Northern Ireland,[34] who were required to pay between £600 and £2,000, including travel and accommodation costs, for abortion services in Great Britain. The financial and logistical difficulties of travelling compelled some women in Northern Ireland to obtain abortions late in the course of their pregnancies, at greater risk to their physical and mental health, or to carry their pregnancies to term. Some underprivileged women received limited financial support from the Abortion Support Network, a non-governmental organization based in England. As from 29 June 2017, women in Northern Ireland seeking a legal abortion in England benefit from National Health Service coverage, however, the Committee notes that the benefit is not guaranteed by law.

27. Testimony revealed that the stress of undergoing an abortion outside Northern Ireland was compounded by logistical arrangements and the secrecy within which they must be made, ultimately having an impact on women's mental health. Logistical arrangements include locating a clinic that offers the correct procedure and its availability within the necessary time frame, procuring transportation and accommodation, arranging for childcare, if necessary, requesting a leave of absence from work and dealing with unforeseen complications, including an extended stay. For women and girls without a driver's licence or passport, securing photographic identification for travel within the tight time frame in which an abortion can be performed is a challenge.

28. The secrecy involved also entails women taking consequential decisions about their health without qualified medical advice. Before the issuance of the draft guidance in 2013, women in Northern Ireland benefited from the medical supervision of abortions in England. The designated members learned about the practice of extracontractual referral to England in cases of fatal fetal abnormality when the procedure is conducted in the second or third trimester of pregnancy, requiring the administration of an injection into the fetus before the abortion.[35] In such cases, physicians in Northern Ireland and England would ensure seamless care during the procedure in England and the delayed expulsion of the fetus in Northern Ireland. That practice has ceased since 2013 owing to uncertainty regarding complicity in a crime.

29. Noting the heavy financial, emotional and logistical burden, the Committee considers that such travel is not a viable solution for women.

[31] Ibid.

[32] See footnote 6 above, para. 2.56. Between 2003 and 2016, the number of non-residents of England and Wales procuring an abortion in England decreased from 9,078 to 4,810.

[33] *Guttmacher Policy Review*, vol. 18, issue 3.

[34] See footnotes 6 and 7 above.

[35] Royal College of Obstetricians and Gynaecologists, "Termination of pregnancy for foetal abnormality in England, Scotland and Wales" (May 2010), pp. 29–31.

(b) Post-abortion care for abortions performed outside Northern Ireland

30. The designated members learned from women in Northern Ireland who had undergone an abortion outside Northern Ireland about the post-procedure mental anguish that they experienced. Women are discharged on the day of the procedure and often, to reduce expenses, immediately return to Northern Ireland, their vulnerable physical and mental state notwithstanding. Once they had returned, women described fearing community stigma and possible prosecution, and hence remained secretive about the abortion, including with their doctors. In addition to descriptions of feeling "dirty", "shameful" or "pressured to just get on with it", the women described how the culture of silence had an impact on their health. There is no systematic sharing of medical records between the abortion facilities outside Northern Ireland and doctors in Northern Ireland, nor do many women wish for their "abortion record" to be transferred. In cases in which women suffer post-procedure complications, lack of any acknowledgement that an abortion was carried out is therefore a barrier to their seeking and receiving appropriate medical care.

31. The Committee notes the confirmation provided by the Chief Nursing Officer of Northern Ireland that "in relation to a procedure which has been performed within the law in Great Britain, our legal advice states that a midwife assisting with the completion of such a termination in Northern Ireland would not be considered to be an accessory in a criminal act".[36] Nonetheless, the designated members heard testimony that health professionals feared prosecution for failing to report women seeking aftercare because they lacked knowledge about the legality of the abortion. Furthermore, the guidance of 2016 indicated the following: "Regardless of where a termination of pregnancy has been carried out, where necessary, support must be provided for individuals through aftercare services, including counselling and other psychological support services. It is the responsibility of Health and Social Care Trusts to provide access to aftercare support for all women where it has been assessed to be required."[37] The Committee notes that no structures, such as bereavement services, exist to support women following an abortion and no official statistics are collected on the number of women who have accessed post-abortion health care or support.[38]

(c) Repatriation of fetal remains

32. A significant source of stress for women who have undergone an abortion outside Northern Ireland is the transportation of fetal remains to Northern Ireland for emotional (bereavement), religious (burial) or medical (DNA testing for genetic abnormalities) reasons or as prosecutorial evidence in rape cases. The designated members learned that residents of Northern Ireland faced difficulties in obtaining DNA analyses in England in cases of fatal fetal abnormality. They are therefore forced to return with fetal remains in order to have thorough tissue testing conducted to determine risk factors for future pregnancies. Testimony revealed that the absence of any established protocols regarding the transfer of fetal remains had resulted in women resorting to undignified transporting practices, including in coolers or hand luggage, at the mercy of airline personnel. Furthermore, no protocol exists on the reception of fetal remains by mortuaries in Northern Ireland. The situation recently

[36] Letter dated 19 March 2009 from the Chief Nursing Officer of Northern Ireland on "foeticide".

[37] See footnote 15 above, paras. 1.7 and 5.15–5.16. See also Northern Ireland Assembly, all questions relating to abortion asked by Clare Bailey to all ministers during the 2016–2017 session.

[38] Northern Ireland Assembly, all questions relating to abortion asked by Steven Agnew to all ministers during the 2016–2017 session.

led to the resignation of one of the only two paediatric pathologists in Northern Ireland.

B. Criminalization of abortion and its effect on women who find themselves in untenable or unplanned pregnancies

33. All the women who were denied access to safe abortion in Northern Ireland who were interviewed by the designated members conveyed their experiences of extreme vulnerability, physical and psychological stress, mental anguish, desperation and isolation in seeking appropriate medical treatment to terminate their pregnancy.

1. Women in situations of poverty

34. The Committee notes that the criminalization of abortion has a particularly adverse impact on women in situations of poverty. Compared with the rest of the United Kingdom, Northern Ireland has: (a) the highest fertility rate; (b) the highest and most persistent levels of child poverty; (c) a higher proportion of single-earner households; (d) lower wage rates; (e) the lowest living standards; (f) the highest childcare costs outside London; and (g) a higher prevalence of poor mental health. The Committee draws a link between the low control that women in Northern Ireland have over their fertility and the disproportionate risk of poverty faced by large families.

35. The Committee notes the views of Justice Horner on the direct correlation between the adverse effects of the criminalization of abortion and worsening socioeconomic status.[39] Notwithstanding the very recent commendable extension of National Health Service coverage to women in Northern Ireland seeking access to abortion in England, the Committee finds that poor women, girls and other women in vulnerable situations are particularly disadvantaged, owing to barriers that they face in terms of the need to travel outside Northern Ireland to gain access to abortion services. Those wishing to continue their pregnancy receive no State support for raising an unplanned child, thereby driving them deeper into poverty, a situation that is exacerbated by recent changes to the distribution of welfare benefits in the United Kingdom, capping the number of new beneficiaries at a maximum of two children per family.

2. Pregnancies resulting from rape or incest

36. There is no exception allowing abortions in cases of rape or incest, not even when the victims are children. The designated members heard testimony about the experience of a 12-year-old girl who travelled to Manchester for an abortion after becoming pregnant following repeated acts of rape by her uncle. She was accompanied by a police officer for the sole purpose of collecting fetal tissue in order to determine the DNA of the accused. The designated members could not ascertain who financed her travel and the procedure or whether she received follow-up health care. A former social worker recounted that social workers sometimes arranged abortions outside Northern Ireland for pregnant adolescents who were under their care.

37. Information transmitted to the designated members revealed the link between the country's recent violent history and the very high rates of sexual abuse experienced by both women and men across Northern Ireland, with estimates that 1 in 4 residents suffer sexual abuse in their lifetime.[40] Statistics show that victims of

[39] See footnote 5 above, para. 154.

[40] Northern Ireland Assembly Research and Information Service, "Rape statistics" research paper (25 February 2015), p. 19.

sexual abuse range from infants to 90-year-old adults, with children consistently accounting for the majority of victims (61 per cent in 2013/14).[41] In the period 2014/15, the police recorded 28,287 incidents of domestic abuse, 2,734 sexual offences and 737 offences of rape.[42] Moreover, the recorded number of sexual offences involving children under 16 years of age has increased dramatically over the past decade.[43]

38. The designated members learned that the criminalization of abortion placed women and girls who were victims of rape or incest at risk of being treated as criminals themselves and had contributed to the underreporting of rape, owing to fear of prosecution and conviction. No data exist on the number of pregnancies resulting from rape or incest or the number of victims seeking an abortion. However, that such crimes can and do result in pregnancies is recognized by the criminal justice compensation scheme in Northern Ireland, under which a victim is granted the amount of £5,500 where a pregnancy is determined to be directly attributable to a sexual offence, irrespective of the victim's age. According to authorities in Northern Ireland, four such payments were made between 2011 and 2016.[44] It is unknown whether State-provided support exists for victims of rape or incest who do not wish to continue the pregnancy. Such support would include psychosocial services during and after pregnancy, facilitation of adoption when requested and financing for raising an unplanned child.

3. Pregnancies involving a fatal fetal abnormality[45]

39. Exceptions allowing abortions are also not available in cases of fatal fetal abnormality.[46] Numerous women recounted their extreme anxiety when, upon receiving a diagnosis of such an abnormality, they had to cope with both the shock of a pregnancy not proceeding as planned and being denied information on the options available to ensure their best health outcome, including on legal choices for abortion that existed outside Northern Ireland and the right to post-abortion care upon return.

40. Most women learn late in their pregnancy (18–20 weeks) of a fatal fetal abnormality, owing to the unavailability in Northern Ireland of publicly funded fetal anomaly tests that could be conducted both before and during the second trimester of pregnancy, in contrast to what is offered under the National Health Service elsewhere in the United Kingdom. The designated members noted that, compared with the rest of the United Kingdom, a greater proportion of fetuses with severe congenital anomalies were carried to term in Northern Ireland, dying shortly after birth.[47] The Committee draws the link between the unavailability of abortions in cases of fatal fetal abnormality and the high stillbirth rate in Northern Ireland, noting that the Belfast Trust reports the highest rates in the United Kingdom.

[41] Ibid., p. 30.

[42] Department of Health, Social Services and Public Safety and Department of Justice of Northern Ireland, "Stopping domestic sexual violence and abuse in Northern Ireland: a seven year strategy" (March 2016), pp. 22–23.

[43] Police Service of Northern Ireland, "Trends in police recorded crime in Northern Ireland 1998/99 to 2014/15" (6 August 2015), p. 17.

[44] Email dated 25 January 2017 from authorities in Northern Ireland, on behalf of the Police Service of Northern Ireland, addressed to the secretariat of the Committee.

[45] Terms to describe fatal fetal impairment include "life limiting abnormality" and "lethal foetal abnormality". Justice Horner noted the implicit value judgment in whatever term was chosen (see [2015] NIQB 96, paras. 5 and 148).

[46] See footnote 2 above, para. 2.9.

[47] See footnote 26 above, pp. 5–6; See also *Belfast Telegraph*, "Belfast has worst stillbirth rate in United Kingdom — medics say abortion laws skew figures" (16 February 2016).

41. Testimony abounds that the late diagnosis of a fatal fetal abnormality and lack of counselling on options for legal abortion results in delayed treatment, with the ensuing physical and psychological trauma for women, which some describe as torture. Women in such situations face severe stress in arranging all logistics within the allowed time limit for procuring a legal abortion outside Northern Ireland, which, in England, is if the pregnancy has not exceeded its twenty-fourth week.[48] The more advanced the pregnancy, the more difficult travelling becomes, the more complex and costly the abortion and the higher the risk of post-abortion complications.

42. In summary, the Committee finds that the criminalization of abortion under the legal and policy framework of Northern Ireland deprives women of any real choice in influencing circumstances affecting their mental and physical health. Being forced either to continue a pregnancy or to travel to receive intimate care in unfamiliar surroundings in the absence of support networks does not represent reasonable or acceptable options, in particular in grievous situations of fatal fetal abnormality, rape or incest, or for children or poor women. Both avenues entail significant physical and psychological suffering. The Committee notes the recent judgment of the Supreme Court of the United Kingdom, in which it accepted as evidence facts closely mirroring the Committee's findings, and upon which the Court concluded that "it remains easy to understand why the plight of women who find themselves in unwanted pregnancy [in Northern Ireland] is deeply unenviable".[49]

C. Inadequacy of family planning support

1. Sexual health education and information

43. The designated members observed that young people in Northern Ireland were denied the education necessary to enjoy their sexual and reproductive health and rights. Most children in Northern Ireland attend denominational schools, either Catholic or Protestant. Church representatives play active roles in school management boards, and the result is that relationship and sexuality education, although a recommended part of the primary and post-primary statutory curriculum of the Department of Education, is underdeveloped or non-existent since it is at the school's discretion to implement the contents of the curriculum according to its values and ethos.[50] Where relationship and sexuality education is delivered, it is frequently provided by third parties and based on anti-abortion and abstinence ethos.[51]

44. The Committee notes that access to abortion services and contraceptives are not statutory requirements of the advisory curriculum.[52] Data show that the rate contraception use among young people in Northern Ireland is lower and their rates of sexually transmitted infections are higher compared with their peers in other parts of the United Kingdom.[53] Furthermore, the prevalence of unplanned teenage pregnancy

[48] Section 1 (1) (a), Abortion Act, 1967 (United Kingdom).

[49] See footnote 6 above, paras. 5–6.

[50] Department of Education Circular 2013/16, "Relationships and sexuality education policy in schools" (25 June 2013); Council for Catholic Maintained Schools Circular 2007/12 (14 March 2007); Department of Education Circular 2015/22, "Relationships and sexuality education guidance" (26 August 2015).

[51] Education and Training Inspectorate, "Report of an evaluation of relationship and sexuality education in post-primary schools" (January 2011).

[52] Council for the Curriculum, Examinations, and Assessment, "Northern Ireland curriculum, relationship and sexuality education guidance — an update for post-primary schools" (2015), pp. 19 and 37.

[53] Family Planning Association, "Teenagers: sexual health and behaviour" (January 2011); *Belfast Telegraph*, "Call for better Northern Ireland sex education as sexually transmitted infections rise" (12 September 2016).

in Northern Ireland is higher compared with other European Union countries, six times higher in deprived areas of Northern Ireland. Those factors point to State negligence in pregnancy prevention through a failure to implement its recommended curriculum on relationship and sexuality education and ensure age-appropriate, culturally sensitive, comprehensive and scientifically accurate sexuality education.

2. Access to reproductive health services and contraceptives

45. The Committee notes the centralized and limited availability of facilities in Northern Ireland providing information, counselling and services in family planning, and in particular about options regarding access to legal abortions in or outside Northern Ireland. Furthermore, medical professionals are neither trained nor encouraged to provide information on abortion options and rely on such information being provided by non-governmental entities.

46. Women attested to difficulties in obtaining modern forms of contraception, such as emergency (morning-after pill), oral, long-term (intrauterine device) and permanent (sterilization). Testimony revealed that women were refused sterilization if they were deemed too young or if they were unmarried and that pharmacists were reluctant to dispense or provide information about emergency contraception.[54]

47. The Committee concludes that women and girls in Northern Ireland are frustrated in their efforts to gain access to the information and services necessary to enjoy their sexual and reproductive health and rights. In the context of a restrictive abortion regime, it leaves women without options for determining the number and spacing of their children.

D. Social context of abortions in Northern Ireland

48. The Committee acknowledges the interconnectedness of the level of access to legal abortion and the sociopolitical and religious context of Northern Ireland, in particular the religious characterization of abortion as a sin. It recognizes that that context informs the positions taken by political parties[55] on amending legislation criminalizing abortion, including the often-cited argument that it could destabilize the peace process or lead to "abortion on demand".

49. Interviews with State and non-State actors in Northern Ireland revealed a lack of political will to change the status quo, epitomized by the Assembly's rejection, in May 2016, of legislative amendments allowing abortion in limited cases of fatal fetal abnormality or sexual crime.[56] The Committee notes attempts by authorities in Northern Ireland to further narrow access to legal abortion through threats to close the sole private abortion provider there.

50. The Committee finds that statements by authorities reinforce the characterization of abortion as a strictly moral issue rather than one of health and human rights. It highlights the Attorney General's statement, in which he drew a parallel between abortions in cases of fatal fetal abnormality and "putting a bullet in the back of the head of the child two days after it's born".[57] It notes a parliamentarian's statement that "the most dangerous place for a child is in its

[54] No pharmacist-wide protocol exists on dispensing emergency contraception in a confidential and gender-sensitive manner.

[55] Letter dated May 2008 addressed to the Members of Parliament of the United Kingdom from four political parties in Northern Ireland.

[56] *Official Report (Hansard), Vol. 112, No. 5*, 10 February 2016.

[57] Comments made by John Larkin, then a Queen's Counsel, during a panel discussion on the BBC programme *Sunday Sequence* (May 2008).

mother's womb".[58] Other statements by politicians and government officials, including the characterization of a woman's primary role as that of mother,[59] have reinforced gender stereotypes steeped in patriarchy, thereby contributing to the belief that it is acceptable to deny women reproductive choice.

51. Moral characterizations of abortion reinforce the stigma associated with the procedure. They perpetuate a culture of silence around the effect of its criminalization and facilitate wilful blindness to the reality faced by women in Northern Ireland. The Committee finds, therefore, that the inadequacy of State-provided family planning support, as driven by socioreligious considerations, coupled with a political culture that circumscribes the role of women, subjects women and girls in Northern Ireland to double jeopardy, effectively depriving them of any control over their fertility.

VI. Legal findings

A. Human rights obligations of decentralized systems

52. The United Kingdom operates a decentralized system of government. Under the policy on legislation concerning devolved matters (referred to as the "Sewel convention"), the central Government would not normally invite Parliament, which retains the right to legislate on all matters, to legislate on devolved matters except upon agreement from the devolved legislature. For Northern Ireland, the Belfast Agreement and the subsequent Northern Ireland Act 1998 (as amended) form the constitutional structure.

53. The United Kingdom argues that, following the devolution of health and criminal law to Northern Ireland, the central Government cannot amend the criminal law of Northern Ireland, including to revise abortion laws. The Committee recalls that, under international law of State responsibility, all acts of State organs are attributable to the State. The Vienna Convention on the Law of Treaties provides, in article 27, that a party to a treaty may not invoke the provisions of its internal law as a justification for its failure to perform it. Moreover, in paragraph 39 of its general recommendation No. 28 (2010) on the core obligations of States parties under article 2 of the Convention, the Committee reiterated that the delegation of government powers did not "negate the direct responsibility of the State party's national or federal Government to fulfil its obligations to all women within its jurisdiction". Thus, the United Kingdom cannot invoke its internal arrangements (the Belfast Agreement) to justify its failure to revise the laws of Northern Ireland that violate the Convention.

B. State party's obligations with regard to the sexual and reproductive health and rights of women under the Convention

54. Article 12 of the Convention, complemented by article 16 (1) (e), guarantees women the right to health, including sexual and reproductive health. The articles require States parties to eliminate discrimination against women in the provision of health care and ensure access to services, including family planning and the right to freely and responsibly decide on the number and spacing of children. Article 12, read with articles 1, 2, 5, 14 and 16 (1) (e), constitutes the legal underpinnings of the Committee's jurisprudence in the area.

[58] Jonathan Bell, member of the Northern Ireland Assembly, 12 March 2013.

[59] F. Bloomer and K. O'Dowd, "Restricted access to abortion in the Republic of Ireland and Northern Ireland: exploring abortion tourism and barriers to legal reform" (2014), p. 3.

55. Under article 2 (c), (d), (f) and (g), States parties are obligated to establish legal protection of the rights of women on an equal basis with men and refrain from engaging in acts or practices discriminatory to women, and to take appropriate measures, including legislation, to modify or abolish existing laws, particularly penal laws, discriminatory to women. Article 2, read with article 1, requires States parties to take appropriate measures to eliminate any restriction having the effect or purpose of impairing or nullifying the enjoyment or exercise by women of human rights in all fields. Article 2 (g) requires States parties to, "repeal all national penal provisions that constitute discrimination against women". Article 5 addresses gender stereotypes, including social and cultural patterns of conduct. Read with articles 12 and 16, it requires States parties to eliminate gender stereotypes that impede equality in the health sector and have a negative impact on women's capacity to make free and informed choices about their health care, sexuality and reproduction.

56. In paragraphs 14 and 31 (c) of its general recommendation No. 24 (1999) on women and health, the Committee states that laws that criminalize medical procedures needed only by women and that punish women who undergo those procedures are barriers to women's access to health care. Since abortion is a service that only women require, the Committee found a violation when access was unduly restricted. In *L.C. v. Peru* (CEDAW/C/50/D/22/2009), the Committee recommended that the State party should review its legislation with a view to decriminalizing abortion when the pregnancy resulted from rape or sexual abuse, having observed that the failure of the State party to protect women's reproductive rights and establish legislation to recognize abortion on the grounds of sexual abuse and rape were facts that contributed to L.C.'s situation (ibid., para. 8.18).

57. In *Da Silva Pimentel v. Brazil* (CEDAW/C/49/D/17/2008) and in paragraph 27 of its general recommendation No. 24, the Committee outlined that States parties should ensure women's right to safe motherhood and obstetric services. Safe motherhood encompasses a series of practices and protocols designed to ensure high-quality services to achieve optimal health for both the pregnant woman and the fetus. That cannot be guaranteed if women are denied information and access to health services and are compelled to carry pregnancies to full term where doing so poses a threat to their health. Optimal health for pregnant women cannot be attained if access to abortion is denied when it is the safest option to address threats to their physical or mental health.

58. Based on its expertise in interpreting articles 12 (1) and 16 (1) (e), its general recommendation No. 24, read with article 2 (b), (d), (e) and (f), as clarified by general recommendation No. 28, and article 5, as clarified by its general recommendation No. 19 (1992) on violence against women and general recommendation No. 35 (2017) on gender-based violence against women, updating general recommendation No. 19, the Committee systematically recommends the decriminalization of abortion in all cases. States parties are obligated not to penalize women resorting to, or those providing, such services (see A/54/38/Rev.1, paras. 185 and 309, and A/55/38, para. 180).

59. Criminal regulation of abortion serves no known deterrent value. When faced with restricted access, women often engage in clandestine abortions, including self-administering abortifacients, at risk to their life and health. In addition, criminalization has a stigmatizing impact on women and deprives them of their privacy, self-determination and autonomy of decision, offending women's equal status, constituting discrimination.[60]

[60] Committee's statement: "Sexual and reproductive health and rights: Beyond 2014 ICPD review".

60. The Committee interprets articles 12 and 16, as clarified by its general recommendation No. 24 and general recommendation No. 28, read with articles 2 and 5, to require States parties to legalize abortion, at least in cases of rape, incest, threats to the life and/or physical or mental health of the woman, or severe fetal impairment. That positive obligation entails providing access to health-care services, including ensuring the provision of accessible and safe, medically approved legal abortions. The Committee consistently discourages the use of abortion as a means of family planning (see A/53/38/Rev.1, para. 66, and A/56/38, para. 62). In that regard, the Committee has emphasized the need to provide contraceptives, including guidance on scientifically sound contraceptive methods to avoid unwanted pregnancies (see A/56/38, para. 62, and CEDAW/C/MKD/CO/3, para. 31). In the inquiry concerning the Philippines, it observed that distinctive health features that differed for women in comparison to men included biological factors such as women's reproductive functions. Given that such factors had a bearing on women's reproductive health needs, the Committee considered that substantive equality required that States parties attend to the risk factors that predominantly affect women. Given that only women can become pregnant, lack of access to contraceptives was therefore bound to affect their health disproportionately (see CEDAW/C/OP.8/PHL/1, para. 111).

61. Post-abortion medical services, regardless of whether abortion is legal, should always be available. In the inquiry concerning the Philippines, the Committee emphasized the need to provide high-quality post-abortion care in all public health facilities, especially in cases in which complications arise from unsafe abortions (ibid., para. 52 (e)).

62. In cases of severe fetal impairment, the Committee aligns itself with the Committee on the Rights of Persons with Disabilities in the condemnation of sex-selective and disability-selective abortions, both stemming from negative stereotypes and prejudices towards women and persons with disabilities. While the Committee consistently recommends that abortion on the ground of severe fetal impairment be made available to facilitate reproductive choice and autonomy, States parties are obligated to ensure that women's decisions to terminate pregnancies on that ground do not perpetuate stereotypes towards persons with disabilities. Such measures should include the provision of appropriate social and financial support for women who choose to carry such pregnancies to term.

63. Rural, migrant, asylum-seeking and refugee women and women in situations of conflict and poverty face additional barriers to access to health care. In paragraph 52 (c) of its general recommendation No. 30 (2013) on women in conflict prevention, conflict and post-conflict situations, the Committee recommended that States parties ensure that sexual and reproductive health care included safe abortion services and post-abortion care. In paragraph 37 of its general recommendation No. 34 (2016) on the rights of rural women, it observed that access to health care, including sexual and reproductive health care, was often extremely limited for rural women. In paragraph 39 (b), it recommended that States parties provide adequate financing of health-care systems in rural areas, in particular with regard to sexual and reproductive health and rights.

C. Violations of rights under the Convention

1. Criminalization of abortion and impeded access to sexual and reproductive health services

(a) Ramifications of criminal sanctions

64. The criminalization of abortion and its availability on limited grounds compel women to travel outside Northern Ireland to procure a legal abortion, to carry their

pregnancy to term if they cannot travel or to procure an illegal abortion in Northern Ireland, risking serious consequences to their health. That scenario creates a socioeconomic split in access to sexual and reproductive health services and carries substantial psychosocial ramifications. It further deepens the socioeconomic divide, given that women who cannot terminate an unwanted pregnancy face long-term adverse economic consequences, linked both to bearing and to raising a child, in particular in the light of the capped welfare benefit scheme for families. Although the maximum penalty of life imprisonment has never been imposed, conviction under lighter penalties has serious ramifications for all aspects of a woman's life.

65. Recalling its general recommendation No. 19 and general recommendation No. 35, discrimination against women includes gender-based violence, which is defined as violence which is directed against a woman because she is a woman or that affects women disproportionately. The restriction, affecting only women, preventing them from exercising reproductive choice and resulting in women being forced to carry almost every pregnancy to full term, involves mental or physical suffering constituting violence against women and potentially amounting to torture or cruel, inhuman and degrading treatment,[61] in violation of articles 2 and 5, read with article 1, of the Convention. It affronts women's freedom of choice and autonomy and their right to self-determination. The mental anguish suffered is exacerbated when women are forced to carry to term a non-viable fetus (in cases of fatal fetal abnormality) or where the pregnancy results from rape or incest. Forced continuation of pregnancy in such scenarios is unjustifiable, State-sanctioned coercion.

66. In defining discrimination, the Convention deliberately adopts a dual "effect" and "purpose" approach in order to capture acts that might have a discriminatory effect even when not intentional. Criminalizing the provision of abortion by medical professionals in effect hinders women's access to sexual and reproductive health services.

(b) De facto unavailability of abortion under the physical or mental health exceptions owing to restrictive interpretation, intimidation and ambiguity

67. The Committee considers that the criteria established under *R v. Bourne* are narrowly construed by authorities and heavily constricted by the qualifications of "long-term or permanent". Consequently, those criteria are hardly ever met in practice. Furthermore, it finds that the State-issued guidance on legal abortion has a chilling effect on health-care professionals, because it is unclear when an abortion performed on the physical or mental health grounds is legal. As a result, they decline all such service provision to avoid criminal sanction. Women who should qualify for a legal abortion under those exceptions are thus compelled to carry pregnancies to term.

(c) Legitimate interest of the State in potential life of the unborn

68. Authorities in Northern Ireland argued that Northern Ireland recognized a right to life of the unborn through its criminal law on abortion. The Committee notes the holding of the Court of Appeal in Northern Ireland that "*Bourne* determined ... that the foetus enjoyed protection under the criminal law subject to the qualification that the mother had a superior right. The foetus did not, therefore, have a right to life

[61] The Human Rights Committee and the Committee against Torture have found that denial of access to abortion services can result in cruel, inhuman and degrading treatment. See *Whelan v. Ireland* (CCPR/C/119/D/2425/2014); *Mellet v. Ireland* (CCPR/C/116/D/2324/2013); *Llantoy Huamán v. Peru* (CCPR/C/85/D/1153/2003); *L.M.R. v. Argentina* (CCPR/C/101/D/1608/2007); CAT/C/PER/CO/5-6, para. 15; and CAT/C/IRL/CO/1, para. 26; see also the Committee's general recommendation No. 35 and footnote 4 above, paras. 60–62.

comparable to that of those who had been born."[62] Under international law, analyses of major international human rights treaties on the right to life confirm that it does not extend to fetuses.[63] Whereas the Committee acknowledges that the State may have a legitimate interest in "prenatal life", criminalizing abortion does not further that purpose. World Health Organization data indicate a direct correlation between restrictive abortion laws and high rates of unsafe abortions, leading to high mortality and morbidity, and that bans or very restrictive abortion laws have no deterrent effect.[64]

(d) Rural women and women in situations of poverty or other form of vulnerability

69. The limited availability of sexual and reproductive services, in particular publicly funded legal abortions in Northern Ireland, limits the options available to rural, migrant, asylum-seeking and refugee women and women in situations of poverty for gaining access to safe abortion services. In the light of the multiple barriers faced by women in those situations to access to abortion both in Northern Ireland and abroad, the Committee notes their susceptibility to turning to unsafe abortion.

(e) Harassment by anti-abortion protesters

70. In violation of their right to seek sexual and reproductive health services and information, women are subjected to harassment by anti-abortion protesters emboldened by lack of prosecution.

(f) Post-abortion care

71. Authorities in Northern Ireland claim that post-abortion care is available irrespective of whether abortions are procured legally or illegally and that no legal repercussions flow from women seeking post-abortion care in any circumstance. Investigations revealed that post-abortion care was unavailable for women procuring abortions legally outside Northern Ireland or illegally in Northern Ireland. Fear of community stigma and criminal prosecution prevents women from seeking care. Health-care professionals, being legally obligated to report suspected crimes, may report women who procure legal abortions outside Northern Ireland, because they cannot ascertain legality in the absence of shared medical records with abortion providers outside Northern Ireland.

(g) Findings

72. The Committee finds that the State party is in violation of the following articles of the Convention:

(a) 1 and 2, read with articles 5, 12 and 16, for perpetrating acts of gender-based violence against women through its deliberate maintenance of criminal laws

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[62] See footnote 6 above, para. 52.

[63] Article 3 of the Universal Declaration of Human Rights limits the right to life to those who have been born. Historical records indicate that the term "born" was intentionally used to exclude the foetus or any other antenatal application of human rights, as confirmed by the refusal to amend the text to remove the term and protect the right to life from conception (see A/C.3/SR.98–99, pp. 110–124. The International Covenant on Civil and Political Rights equally rejects the proposition that the right to life protected under article 6 (1) applies before birth. As noted in the *travaux préparatoires*, a proposed amendment, stating that: "the right to life is inherent in the human person from the moment of conception, this right shall be protected by law", was subsequently rejected (see A/C.3/L.654 and A/3764, para. 119).

[64] World Health Organization, *Safe abortion: technical and policy guidance for health systems* (2012).

disproportionately affecting women and girls, subjecting them to severe physical and mental anguish that may amount to cruel, inhuman and degrading treatment;

(b) 12, for failing to respect women's right to health by obstructing their access to health services, including through laws criminalizing abortion, which punish women and those assisting them, and by rendering access to post-abortion care, irrespective of the legality of the abortion, inaccessible owing to clinicians' fear of prosecution;

(c) 2, 12 and 16, for denying women the right to decide freely and responsibly on the number and spacing of their children and the right to have access to the information, education and means to enable them to exercise that right;

(d) 2, 12, 14 (2) (b) and 16 (1) (e), read with article 1, for dereliction of its public health duties. The concentration of sexual and reproductive services in Belfast and the abdication of responsibility to ensure access to abortion in Northern Ireland by exporting the problem to England has serious impacts on disadvantaged groups unable to travel for socioeconomic reasons, exacerbating the multiple forms of discrimination already suffered by rural, migrant, asylum-seeking and refugee women and women in situations of poverty;

(e) 10 and 12, for failing to protect women from harassment by anti-abortion protesters when seeking sexual and reproductive health services and information.

2. Gender stereotypes

73. Information obtained revealed the following:

(a) The prevalence of discriminatory gender stereotypes portraying a woman's primary role as that of mother, as rooted in culture and religion;

(b) Politicians' statements that vilify women and foment negative stereotypes regarding reproduction;

(c) The societal ostracization and religious condemnation of women who undergo an abortion, breeding fear and hindering access to sexual and reproductive health services and information;

(d) The non-existence of policy to counter existing negative stereotypes, which condones a culture of silence and stigma;

(e) Health-care facilities suffused with negative stereotypes regarding women primarily as mothers, impeding the provision of evidence-based and scientifically sound information and services on pregnancy prevention and termination.

Findings

74. The Committee finds that the failure to combat stereotypes depicting women primarily as mothers exacerbates discrimination against women and violates article 5, read with articles 1 and 2, of the Convention.

3. Access to sexual health education

75. The provision of age-appropriate, culturally sensitive, comprehensive and scientifically accurate sexuality education and information is critical to the realization of women's right to health. Leaving the delivery of the curriculum on relationship and sexuality education at the discretion of schools results in poor-quality sexuality education for young people and the indoctrination of anti-abortion and abstinence ethos.

Findings

76. The Committee finds that the State party has failed to prioritize the prevention of unplanned pregnancy through the provision of high-quality sexuality education. Its lack of oversight of delivery by schools of the curriculum on relationship and sexuality education, to ensure that it is evidence-based and includes contraceptive use, safe abortion and post-abortion care, violates article 10 (h) of the Convention.

D. Principal findings of violations under the Convention

77. In the light of the foregoing, the Committee finds that the State party has violated the following articles of the Convention: 12 read alone; 12 read with 2 (c), (d), (f), (g), 5 and 10 (h); 10 (h) read with 16 (1) (e); 14 (2) (b) read alone; and 16 (1) (e) read alone. Those articles should be read together with the Committee's general recommendation No. 19, general recommendation No. 35, general recommendation No. 21 (1994) on equality in marriage and family relations, general recommendation No. 24, general recommendation No. 26 (2008) on women migrant workers, general recommendation No. 28, general recommendation No. 32 (2014) on the gender-related dimensions of refugee status, asylum, nationality and statelessness of women, general recommendation No. 33 (2015) on women's access to justice and general recommendation No. 34.

E. Grave or systematic nature of the violations

78. Pursuant to article 8 of the Optional Protocol and rule 83 of its rules of procedure, the Committee must assess whether the violations of rights are grave or systematic.

79. The Committee considers violations to be "grave" if they are likely to produce substantial harm to victims. A determination regarding the gravity of violations must take into account the scale, prevalence, nature and impact of the violations found.[65]

80. The term "systematic" refers to the organized nature of the acts leading to the violations and the improbability of their random occurrence.[66] The Committee has stressed that a "systematic denial of equal rights for women can take place either deliberately, namely with the State party's intent of committing those acts, or as a result of discriminatory laws or policies, with or without such purpose".[67]

81. The Committee assesses the gravity of the violations in Northern Ireland in the light of the suffering experienced by women and girls who carry pregnancies to full term against their will owing to the current restrictive legal regime on abortion. It notes the great harm and suffering resulting from the physical and mental anguish of carrying an unwanted pregnancy to full term, especially in cases of rape, incest and severe fetal impairment, in particular fatal fetal abnormality.[68] The situation gives women in Northern Ireland three deplorable options: (a) undergo a torturous experience of being compelled to carry a pregnancy to full term; (b) engage in illegal abortion and risk imprisonment and stigmatization; or (c) undertake a highly stressful journey outside Northern Ireland to gain access to a legal abortion. Women are thus torn between complying with discriminatory laws that unduly restrict abortion or risking prosecution and imprisonment.

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[65] See footnote 61 above, para. 47; see also CEDAW/C/OP.8/CAN/1, para. 213.

[66] See footnote 61 above, para. 48; see also CEDAW/C/2005/OP.8/MEXICO, para. 261.

[67] See footnote 61 above, para. 48.

[68] *Mellet v. Ireland*.

82. The systematic nature of the violations stems from the deliberate retention of criminal laws and State policy disproportionately restricting access to sexual and reproductive rights, in general, and the highly restrictive provision of abortion, in particular. Authorities in England and in Northern Ireland acknowledge the magnitude of the phenomenon and choose to export it to England, where women travel from Northern Ireland to gain access to abortion services. The observations of the United Kingdom and interviews with authorities in Northern Ireland clarify the deliberate intention neither to decriminalize abortion nor to expand the grounds for legal abortion. The availability of abortion in other parts of the State party does not absolve it of its responsibility under the Convention to ensure accessibility in Northern Ireland.

83. The Committee finds that the State party is responsible for the following:

(a) Grave violations of rights under the Convention, considering that the State party's criminal law compels women in cases of severe fetal impairment, including fatal fetal abnormality, and victims of rape or incest to carry pregnancies to full term, thereby subjecting them to severe physical and mental anguish, constituting gender-based violence against women;

(b) Systematic violations of rights under the Convention, considering that the State party deliberately criminalizes abortion and pursues a highly restrictive policy on access to abortion, thereby compelling women to carry pregnancies to full term, to travel outside Northern Ireland to undergo legal abortion or to self-administer abortifacients.

VII. Recommendations

84. In the light of the foregoing and in line with relevant recommendations addressed to the State party by other United Nations bodies, the Committee refers to its previous concluding observations (see CEDAW/C/GBR/CO/7, paras. 50–51) and recommends the following to the State party, focusing on Northern Ireland.

A. Legal and institutional framework

85. **The Committee recommends that the State party urgently:**

(a) **Repeal sections 58 and 59 of the Offences against the Person Act, 1861, so that no criminal charges can be brought against women and girls who undergo abortion or against qualified health-care professionals and all others who provide and assist in the abortion;**

(b) **Adopt legislation to provide for expanded grounds to legalize abortion at least in the following cases:**

(i) **Threat to the pregnant woman's physical or mental health, without conditionality of "long-term or permanent" effects;**

(ii) **Rape and incest;**

(iii) **Severe fetal impairment, including fatal fetal abnormality, without perpetuating stereotypes towards persons with disabilities and ensuring appropriate and ongoing support, social and financial, for women who decide to carry such pregnancies to term;**

(c) **Introduce, as an interim measure, a moratorium on the application of criminal laws concerning abortion and cease all related arrests, investigations**

and criminal prosecutions, including of women seeking post-abortion care and health-care professionals;

(d) Adopt evidence-based protocols for health-care professionals on providing legal abortions particularly on the grounds of physical and mental health and ensure continuous training on the protocols;

(e) Establish a mechanism to advance women's rights, including through monitoring authorities' compliance with international standards concerning access to sexual and reproductive health, including access to safe abortions, and ensure enhanced coordination between the mechanism with the Department of Health, Social Services and Public Safety and the Northern Ireland Human Rights Commission;

(f) Strengthen existing data-collection systems and data sharing between the Department and the police to address the phenomenon of self-induced abortion.

B. Sexual and reproductive health rights and services

86. **The Committee recommends that the State party:**

(a) Provide non-biased, scientifically sound and rights-based counselling and information on sexual and reproductive health services, including on all methods of contraception and access to abortion;

(b) Ensure the accessibility and affordability of sexual and reproductive health services and products, including on safe and modern contraception, including oral, emergency, long-term and permanent forms of contraception, and adopt a protocol to facilitate access at pharmacies, clinics and hospitals;

(c) Provide women with access to high-quality abortion and post-abortion care in all public health facilities and adopt guidance on doctor-patient confidentiality in that area;

(d) Make age-appropriate, comprehensive and scientifically accurate education on sexual and reproductive health and rights a compulsory component of curriculum for adolescents, covering prevention of early pregnancy and access to abortion, and monitor its implementation;

(e) Intensify awareness-raising campaigns on sexual and reproductive health rights and services, including on access to modern contraception;

(f) Adopt a strategy to combat gender-based stereotypes regarding women's primary role as mothers;

(g) Protect women from harassment by anti-abortion protesters by investigating complaints and prosecuting and punishing perpetrators.